SERFF Tracking Number:	*UCTA-128114540*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care - Applications*		
Project Name/Number:	*/*		

Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Short Term Care - Applications	SERFF Tr Num: UCTA-128114540	State: Arkansas
TOI: H13I Individual Health - Short Term Care	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H13I.002 Nursing Home	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Denise Sharif, Jane Visocan, Lyndsay Fields	Disposition Date: 02/27/2012
	Date Submitted: 02/24/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 02/27/2012
	State Status Changed: 02/27/2012
Deemer Date:	Created By: Denise Sharif
Submitted By: Jane Visocan	Corresponding Filing Tracking Number:

Filing Description:

February 22, 2012

Arkansas Insurance Department
1200 W 3rd St.
Little Rock, AR 72201

RE: The Order of United Commercial Travelers of America

SERFF Tracking Number:	*UCTA-128114540*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care - Applications*		
Project Name/Number:	*/*		

NAIC number: 56383
FEIN number: 31-4273120

SUBMISSION

Application: STC APP 12 AR
Reinstatement Application: STC COH 12 AR

We are requesting the Department's review and approval of this filing. The filing consists of an application and an application for reinstatement for Short Term Care Insurance.

The application is replacing Form number STC APP 1/09 AR REV which was previously approved on September 3, 2009. It is being revised to update the authorization language; none of the health questions have been changed.

Any required filing documents have been completed and are included with the filing.

We appreciate your time and consideration in the review of this filing. Thank you.

Sincerely,

Denise Sharif
Compliance Supervisor
(800) 848-0123, Ext. 103
Email: dsharif@uct.org

Company and Contact

Filing Contact Information

Denise Sharif, Compliance Supervisor	dsharif@uct.org	
1801 Watermark Dr.	614-487-9680 [Phone] 103 [Ext]	
Suite 100	614-487-9675 [FAX]	
Columbus, OH 43215		

Filing Company Information

The Order of United Commercial Travelers of America	CoCode: 56383	State of Domicile: Ohio
1801 Watermark Dr.	Group Code:	Company Type:
Suite 100	Group Name:	State ID Number:

SERFF Tracking Number:	*UCTA-128114540*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care - Applications*		
Project Name/Number:	*/*		

Columbus, OH 43215 FEIN Number: 31-4273120

(614) 487-9680 ext. 103[Phone]

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	AR basis - $50 per form OH basis - $50 per company per filing
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	$100.00	02/24/2012	56632786

SERFF Tracking Number:	*UCTA-128114540*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care - Applications*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/27/2012	02/27/2012

SERFF Tracking Number:	*UCTA-128114540*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care - Applications*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 02/27/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UCTA-128114540*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care - Applications*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Reinstatement Application	Approved-Closed	Yes

SERFF Tracking Number:	*UCTA-128114540*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care - Applications*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/27/2012	STC APP 12 AR	Application/ Enrollment Form	Application	Initial		40.800	STC APP 12 AR.pdf
Approved-Closed 02/27/2012	STC COH 12 AR	Application/ Enrollment Form	Reinstatement Application	Initial		44.100	STC COH 12 AR.pdf

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 800.948.1039 • www.uct.org

APPLICATION FOR SHORT TERM CARE INSURANCE POLICY

Requested Effective Date of Policy

APPLICANT

Last *First* *MI*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

APPLICANT'S ADDRESS

Street: _____

_____

City: _____

State: _____ *Zip Code:* _____

Telephone: (_____) _____- _____

Underwriting Risk Classification Question

Have you used any form of tobacco in the past two years? ☐ Yes ☐ No

Are you a member of The Order of United Commercial Travelers of America? ☐ Yes ☐ No

Council Name: _____ **Council Location (City & State):** _____

Is your spouse also applying for the Short Term Care Insurance Policy? ☐ Yes ☐ No
If yes, please complete:

Last Name: _____ *First Name:* _____

HEALTH QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1. Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting? ☐ Yes ☐ No
2. Do you require assistance with shopping, housekeeping or cooking? ☐ Yes ☐ No
3. During the past two (2) years have you:
   (a) Been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living? ☐ Yes ☐ No
   (b) required any assistance with mobility including the use of a walker, multi-pronged cane, walking aids, wheelchair, or scooter? ☐ Yes ☐ No
4. Are you currently bedridden, hospitalized or have you been hospitalized two or more times within the past year? ☐ Yes ☐ No
5. Within the past two years, have you been advised to have kidney dialysis, had a heart attack, stroke or heart valve surgery, been recommended to have surgery but not had such surgery, had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse? ☐ Yes ☐ No
6. Have you had or been told by your physician you needed amputation due to disease, you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
7. Do you receive Federal, state or local government financial assistance in any form, such as Supplemental Security Income or Medicaid? ☐ Yes ☐ No
8. Are you an insulin dependent diabetic? ☐ Yes ☐ No

BENEFIT OPTIONS

☐ **Short Term Care Insurance Policy** **Maximum Daily Benefit Amount: $ _____** **Elimination Period** ☐ **0 Days** ☐ **20 Days**

Maximum Benefit Period ☐ **100 Days** ☐ **200 Days** ☐ **360 Days**

Optional Riders ☐ **Home Health Care** ☐ **Compound Inflation Protection**

REPLACEMENT INFORMATION (MUST BE COMPLETED)

1. Do you have another insurance policy in force (including health care service contract or health maintenance organization contract)? ..... ☐ Yes ☐ No
2. Did you have another limited benefit policy in force during the last six (6) months? ..... ☐ Yes ☐ No

If yes, with which company: (Name and address): _____

_____

_____

Policy Number: _____ If that policy lapsed, when did it lapse? _____

Daily Benefit Amount: $ _____ Benefit Period _____

Do you intend to replace any of your medical or health insurance coverage with this policy? ..... ☐ Yes ☐ No
If yes, please read and sign the replacement notice provided by the agent.

Authorizations and Signatures

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Signed At: _____Applicant's Signature: _____

Dated: _____
(Month/Day/Year)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____

_____

_____

_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____

_____

_____

_____

I certify that:
1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

_____ _____

Agent's Signature **Date**

_____ _____

Agent's Printed Name **Agent No.**

AUTHORIZATION & ACKNOWLEDGEMENT
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical or medically-related facility, insurance company, MIB, Inc., consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or prescription drug usage or having any non-medical information concerning me to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that I am authorizing The Order of United Commercial Travelers of America to receive my health information or prescription drug usage history and my non-medical information. I understand that when my health information is disclosed pursuant to this Authorization, my medical records and the Information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I authorize The Order of United Commercial Travelers of America, or its reinsurers, to make a brief report of my protected health information to MIB, Inc.

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America . I understand that failure to provide the authorization to The Order of United Commercial Travelers of America *will* result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative may request to receive a copy of this authorization.

Applicant's Name: _____

Social Security Number: _____ **Date of Birth:** _____

Applicant's Signature: _____ **Date:** _____

NOTICE TO APPLICANT

In making this application for insurance to The Order of United Commercial Travelers of America, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential. The Order of United Commercial Travelers of America, or its reinsurer, may; however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Braintree, Massachusetts 02184-8734.

The Order of United Commercial Travelers of America, or its reinsurer, may also release information from its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly EFT

Short Term Care Only Premium	**$ _____**
Home Health Care Rider Premium	**$ _____**
Compound Inflation Protection Rider Premium	**$ _____**
SUBTOTAL	**$ _____**
Less Spousal Discount (If Applicable)	**$ _____**
Less Non-Tobacco Discount (If Applicable)	**$ _____**
TOTAL MODAL PREMIUM	**$ _____**
Modal Fraternal Dues (If Applicable)	**$ _____**
TOTAL MODAL AMOUNT DUE	**$ _____**
TOTAL AMOUNT PAID WITH APPLICATION	**$ _____**

AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK
Deposit Slips NOT Accepted

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, Box 159019, Columbus, Ohio 43215-8619.

Name of Bank Customer: _____

Insured's Name: _____

Account Number: _____ **Routing Number:** _____

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	**Signature of Bank Customer**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.
To: Bank above:

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

UCT Where Community and Compassion Unite

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

CERTIFICATE OF HEALTH
APPLICATION FOR SHORT TERM CARE INSURANCE REINSTATEMENT

POLICY NUMBER:	**RESIDENCE ADDRESS** ***Street:*** _____ ***City:*** _____ ***State:*** _____ ***Zip Code:*** _____ ***E-mail:*** _____ ***Telephone:*** _____
NAME OF INSURED:	

HEALTH QUESTIONS

1. Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting? ☐ Yes ☐ No
2. Do you require assistance with shopping, housekeeping or cooking? ☐ Yes ☐ No
3. During the past two (2) years have you:
   (a) Been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living? ☐ Yes ☐ No
   (b) required any assistance with mobility including the use of a walker, multi-pronged cane, walking aids, wheelchair, or scooter? ☐ Yes ☐ No
4. Are you currently bedridden, hospitalized or have you been hospitalized two or more times within the past year? ☐ Yes ☐ No
5. Within the past two years, have you been advised to have kidney dialysis, had a heart attack, stroke or heart valve surgery, been recommended to have surgery but not had such surgery, had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse? ☐ Yes ☐ No
6. Have you had or been told by your physician you needed amputation due to disease, you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
7. Do you receive Federal, state or local government financial assistance in any form, such as Supplemental Security Income or Medicaid? ☐ Yes ☐ No
8. Are you an insulin dependent diabetic? ☐ Yes ☐ No

I understand and agree that this application will become a part of the policy contract; and that any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

Signature of Applicant: _____ Date: _____

If phone interview to be completed.

Daytime Phone No.: (_____)_____-_____Best Time to Call:_____

AUTHORIZATION & ACKNOWLEDGEMENT
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical or medically-related facility, insurance company, MIB, Inc., consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or prescription drug usage or having any non-medical information concerning me to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that I am authorizing The Order of United Commercial Travelers of America to receive my health information or prescription drug usage history and my non-medical information. I understand that when my health information is disclosed pursuant to this Authorization, my medical records and the Information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I authorize The Order of United Commercial Travelers of America, or its reinsurers, to make a brief report of my protected health information to MIB, Inc.

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America . I understand that failure to provide the authorization to The Order of United Commercial Travelers of America *will* result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative may request to receive a copy of this authorization.

Applicant's Name: _____

Social Security Number: _____ Date of Birth: _____

Applicant's Signature: _____ Date: _____

SERFF Tracking Number:	*UCTA-128114540*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care - Applications*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/27/2012

Comments:
Please see the attached.
Attachment:
STC Read Cert 2-22-12.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/27/2012
Bypass Reason:	this is an application filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	02/27/2012
Bypass Reason:	not applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	02/27/2012
Bypass Reason:	not applicable		
Comments:			

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

The Order of United Commercial Travelers of America
1801 Watermark Dr., Suite 100
Columbus, OH 43215

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Title of Form	Form Number	Flesch Score
Application for Short Term Care Insurance	STC APP 12	40.8
Application for Reinstatement of Short Term Care Insurance – Certificate of Health	STC COH 12	44.1

In determining the Flesch Scores shown above, the following "text" was excluded:

1. The name and address of the company;
2. The name, number and title of the form;
3. The table of contents or index;
4. Captions and sub-captions;
5. Specification pages, schedules and tables;
6. Any provisions required by federal law or regulation; and
7. Any medical terminology.

The type size of the text is at least 10-point.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in the state.

Signature of Insurance Company Officer